This tool kit is designed to facilitate the implementation, evaluation and maintenance of improved ways to close the referral loop between primary care and specialist physicians. The tool kit includes resources and guidance based on the experience and lessons learned during a pilot project supported by PCPI and The Wright Center for Graduate Medical Education.

Closing the Referral Loop

A tool kit to improve the referral management process between primary care and specialist physicians

From: PCPI and the Wright Center for Graduate Medical Education
Closing the Referral Loop:

A tool kit to improve the referral management process between primary care and specialist physicians

A Collaborative effort of PCPI and The Wright Center for Graduate Medical Education.
The Closing the Referral Loop Expert Panel

In 2013, PCPI identified ambulatory referral as a key area for improvement through an extensive literature search and a focus group of national improvement experts. Subsequently, an expert panel was convened with participants representing organizations, which had tested a single strategy to improve the referral process. The expert panel included the following individuals:

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The following individuals were responsible for the leadership of the pilot project, which operated in 2014 and 2015.

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We would like thank Dana Richardson, RN, MHA, who served as Director of PCPI Operations and Strategic Initiatives at the American Medical Association, for her early leadership and support of the Closing the Referral Loop project.
# PCPI Closing the Referral Loop Tool Kit

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Preface
This tool kit is designed to facilitate the implementation, evaluation and maintenance of improved ways of closing the referral loop between primary care and specialist physicians. Closing the Referral Loop has been identified as a major issue and will only increase in importance as more and more patient care is conducted outside the inpatient setting. This improvement work defined and measured referral types using time-stratified definitions. It quantified the expectations of primary care and specialty physicians in terms of referral initiation and completion and evaluated related satisfaction of primary care, specialist and patient with changes in the referral process. In addition, a major goal of referral redesign was to maximize the use of the EHR in managing referrals.

The tool kit includes resources and guidance based on the experience and lessons learned during a pilot project supported by PCPI and The Wright Center for Graduate Medical Education.

The pilot in two ways clearly identified that the role of the physician is crucial in ensuring that the referral loop is closed. The first was that although the physicians involved were not necessarily the people doing the work to create the structural changes, physician leadership in the dyad (primary care and specialty offices) was necessary for change to occur. That means that physicians needed to articulate the importance of the work to their staff members and strongly communicate the need for change. Second, physician leadership was necessary to establish efficient and effective communications between primary care and specialist physicians and between their referral staff. The dyad needed to have explicit conversations about the changes that needed to occur within their offices and accountability related to implementation of the changes (outlined in the Care Compact, which is discussed in the tool kit’s change ideas).

One physician noted in the evaluation of the pilot that, “The process for change rests with the staff—they need to understand the value for change, as well as how to make it happen. But the physicians need to make sure they are making it happen.”

Each practice within the dyad (primary care and specialty) had unique characteristics. The change package and recommendations in the tool kit are a distillation of lessons learned in working with 12 diverse dyads of clinicians with nine different electronic health records (EHRs), in both the academic and non-academic setting.

Many challenges identified in the pilot project would be addressed if there was universal interoperability between EHRs. Although PCPI is in discussions to develop a minimum standard for interoperability with a work group facilitated by the U.S. Office of the National Coordinator for Health IT (ONC), this tool kit will help arm you with knowledge to improve the referral management process and develop processes that can serve as effective stopgap activities now.

If you need additional information about the Closing the Referral Loop pilot project, or seek additional guidance, please email: info@thepcpi.org
Introduction – Why Change?

More than 105 million referrals of Medicare beneficiaries are made between primary care and specialist physicians in the U.S. every year. Care coordination and the relationships between primary care physicians, specialists and patients have become complex as a result of multiple providers working in different settings and the widespread use of disparate electronic health records (EHRs). The PCPI, in collaboration with The Wright Center for Graduate Medical Education, sponsored the Closing the Referral Loop (CRL) pilot project, which involved 12 dyads of primary care and specialist physicians to: improve the process for physician-to-physician referrals in the ambulatory setting by establishing accountability and improving information transfer; and achieve higher satisfaction and understanding of the referral process among patients and physicians. A change package of interventions was developed. Using the Institute for Healthcare Improvement (IHI) Breakthrough Series Collaborative model, participating dyads were able to increase the number of closed referrals from 40% to 70%, increase the referrals with clinical question answered from 50% to 75%, and significantly improve physician satisfaction with the referral process. Due to the inability to communicate with one another, the use of disparate EHRs was a major barrier. The success and lessons from the pilot project are the basis for this Closing the Referral Tool Kit, which provides an opportunity for broad scale and spread of the change package to improve ambulatory referral management.

“It is apparent that the CRL Pilot created room for change to occur and for positive outcomes to be produced. The pilot both ignited a spark and provided a structure for change.”

From the Closing the Referral Loop Evaluation of the 2014 Pilot Project, The Evaluation Institute, Graduate School of Public Health, University of Pittsburgh, September 2015.

Reference

About the Pilot Project
The purpose of the pilot project was to improve the efficiency and effectiveness of the referral processes between primary care physician (PCP) and specialist offices so that 1) the PCP’s reason for the referral is clearly stated, 2) PCP referral is sent in a timely manner with clear and consistent supporting information, 3) specialist response clearly addresses the reason for the referral, 4) timely completion and receipt of referral report improves, 5) satisfaction of the PCP, the specialist, and the patient with the referral process improves, and 6) use of the EHR in supporting the referral processes is maximized to increase reliability and consistency.

The pilot project used the Institute for Healthcare Improvement’s (IHI) Breakthrough Series Learning Collaborative Model (a pre-work period and two, 4-hour in-person learning sessions, separated by one action period) to test interventions within and across health care organizations during the 18-month life of the project. Twelve (12) “dyads” (PCP and specialist), as well as their staff participated in the pilot project, collected data on a defined set of measures, attended monthly improvement webinars and in-person meetings to share challenges, and shared solutions and lessons learned. The improvement coach initiated and participated in site visits to all dyads. The dyads included physicians who were independent and/or affiliated with systems or academic medical centers. Participating dyads had access to a library of improvement information including documents related to the interventions to be tested. Nine different EHRs were used across these practice sites.

The project was overseen by a leadership team and managed by a project team comprised of members from the collaborating partners. The PCPI provided access to referral process experts, as well as improvement and measurement system expertise. The Wright Center provided improvement expertise (coach and IHI-trained improvement advisor) to develop the change package, tools, and educational material; data collection and analysis services; recruitment support for participating dyads; and team and meeting coordination. The Wright Center primary care internal medicine residents and cardiology fellows were trained and served as quality improvement coaches for the dyads and their staff, assisted sites with data collection and prepared storyboards for the in-person learning sessions. In addition, the change package at the center of the collaborative focused on completion of a shared care compact with agreed upon referral types including time stratified definitions; clarification and response to the clinical question; evaluation of specifications used in electronic communication to share patient information and enhance EHR interoperability; and messaging and the exchange of health information.

The pilot study was funded by PCPI through a payment to The Wright Center for Graduate Medical Education. Funding supported meeting and other logistical support. The Wright Center provided funding for the improvement advisor. Both organizations provided staff expertise and management throughout the project. Dyad sites were not reimbursed to participate in this project.
The Referral Management Process

The following graphic (Figure 1.) reflects a general referral process, initiated by a PCP ordering a patient’s referral to a specialist, the PCP office sending the referral to the specialist, the specialist securing an appointment with the referred patient, the specialist completing the requested referral, the specialist sending a report to the PCP, the PCP reviewing the report findings, and finally the PCP discussing the subsequent plan with the patient. The way the process should work ideally.

Figure 1

Referral Process Map

1. Primary Care Physician (PCP) orders the referral to the specialist
2. PCP referral staff complete referral forms and send to the specialist office
3. Specialist staff receive referral request
4. Specialist staff schedules appointment with the patient
5. Specialist sees patient and completes/sends referral report to PCP
6. PCP receives and reviews referral report and discusses with patient
Typical Referral Request Workflow Found in Pilot Projects

In the pilot project, the most common workflow for requesting a referral is summarized in Figure 2. Please note that Figure 2 reflects the key responsibilities of the PCP, the key responsibilities of the Specialist, and the key components of the outgoing referral document.

The PCP identifies the need for a referral, enters the referral into the EHR, and sends the referral to the Referral Coordinator (RC). The RC faxes the referral to the specialist’s office staff via the EHR. The PCP’s RC then attaches and sends the Summary of Care Record with the referral to the specialist that includes: Care Plan field (goals and instructions), care team (other providers), reason for referral (clinical question), current problem list, current medication list, and current allergy list.

Figure 2.
Resources for process flow mapping
Mapping the process flow for referral management in your clinic and with your physician counterparts in the referral process, whether primary care or specialist, will be a critical step in understanding the barriers to Closing the Referral Loop in your practice. Once the process is mapped, gaps will be obvious and the places for you to focus your attention will be clear.

There are several resources available to assist you with process mapping including the American Society of Quality (ASQ) website:


Mapping Work Processes. Bjørn Andersen, Tom Fagerhaug, Bjørnar Henriksen, and Lars E. Onsøyen
http://asq.org/quality-press/display-item/?item=H1170

You may find these additional resources helpful: http://www.six-sigma-material.com/Process-Maps.html

Referral Process Change Strategies Implemented
Many of the change strategies implemented by the PCPs involved working with the EHR vendors to create EHR capabilities to include creating an electronic referral request, identifying the type of referral ordered (urgent vs. priority vs. routine), attaching the “Clinical Question” to the referral, and creating trackable fields for DOA (Date of Appointment) and attachment of the specialist note. In addition, the PCP needed to be able to extract reports to include the list of open referrals by specialist, the time from referral created to referral sent to specialist, the time from referral sent to specialist to appointment date, referral closed date in relation to specialist appointment with the patient, and the ability to organize referral data as Urgent, Priority, or Routine.

EHR related change strategies that were implemented by the Specialists included organizing incoming referral by their importance (Urgent vs. Priority vs. Routine), identifying the “Clinical Question” asked, electronically communicating the date of appointment or the date of contact, and electronically sending the note with the answer to the “Clinical Question.” the specialist also needs to be able to extract reports to include time from referral received to appointment date and time from appointment to note sent to PCP.

In general, the EHR needs to identify and be able to report the dyad physicians (PCP and Specialist), linked clinical question document, and create/sent date, appointment date and time (made by specialist’s office). The EHR also needs the capability of updating and entering referral data at a later date into the same referral document.
Measures
Based on the pilot project, PCPI recommends using the following six measures for assessing your improvement efforts.

Table B.

<table>
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<tr>
<td>1. Total number of referrals by type:</td>
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<tr>
<td>o Priority (7-14 days)</td>
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<td>o Routine (14-28 days)</td>
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<td>2. Number of Referrals closed in a timely manner</td>
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Referrals are the number of patients referred from the PCP to the specialist over a rolling 3-month period. “Closed in a timely manner” refers to referrals where a specialist note was received by the PCP within 7 days of the specialist appointment.

Results
Toward the end of the project (after Learning Session 2), 95% of the referral requests were Routine Referrals (closed within 14 to 28 days). The request for urgent and priority referrals became non-existent at less than 5%. This change suggests greater reliability and consistency in the referral process over time. The percentage of closed referrals increased from 40% pre-intervention (prior to and including Learning Session 1) to 70% post-intervention (post Learning Session 1 through Learning Session 2). In addition, referrals with the clinical question answered by specialist increased from 50% pre-intervention to 75% post-intervention. Patient satisfaction with the referral process remained at a high level with little change across the length of the project. Post-intervention physician satisfaction with the referral process improved as compared to pre-intervention with the specialist satisfaction improving significantly. Additional data will be reported in the CRL article now being prepared for submission.
Implementation Time Line and Project Plan

To aid you in your improvement planning, we have developed a sample implementation time line and project plan based on our experience and lessons learned in the pilot project (** indicates lessons learned). In the project plan we are also identifying specific resources included in this tool kit that you may to use in your implementation.

Planning Phase Activities (months 1-2)

1. Select a specific PCP-Specialist dyad for referral process improvement who can each serve as the champion of change for each practice by identifying physicians (PCP and Specialist) that have worked together for years; have a good relationship regarding referrals with routine PCP ordering of referrals to the Specialist; have a significant volume of referrals from PCP practice to Specialist practice to enhance spread and support process redesign and testing; if possible, practice in the same health system or ACO (with same EHR, expectations, etc.); and have interest in improving the referral process.

2. Identify the staff members at each practice (PCP and specialist) that are routinely involved in managing referrals, improving office quality, and using the EHR effectively (including team members comfortable with your EHR and data systems).

3. Schedule consistent dyad team meetings to focus on mapping the current referral process including roles and responsibilities of each member; use of the EHR in establishing a referral registry and identifying the start and completion of each process step; use of the EHR in communicating referral issues between the dyad teams. **

4. Collect and analyze data on your current timeframes for completion of each process step and overall completion of a closed referral. Identify gaps in care.

5. Identify types of referrals managed by the dyad based on clinical issues and related timeframes within the referral report must be closed (review referral definitions within the tool kit).

6. Use the Readiness Assessment included in this tool kit’s Appendices.

7. Survey both primary care and specialist physicians to determine baseline status of satisfaction regarding the referral process (sample satisfaction surveys for the PCPs and Specialists are included in the tool kit).

Implementation Phase Activities (months 3-4)

1. Complete Care Compact with partner specialist practice to set expectations for both practices (see sample Care Compact in tool kit). This needs to be completed before redesigning referral management process. Make sure types of referrals are defined. **

2. Develop specific aims that are SMART (Specific, Measurable, Achievable, Realistic and Time-bound)

3. Redesign the referral management process based on your findings during the Planning Phase incorporating ideas from this tool kit.

4. Identify and assign lead staff to test and operationalize changes – should have a strong understanding of referral process and electronic systems that support or need to support referral management and closing the referral loop.
5. Develop any paper or electronic tools needed to support referral management process (this may include templates for asking and answering the clinical question to be attached in EHR or though instant messaging platform, or fields within existing EHR. If unable to work with EHR vendors to increase interoperability of the two EHRs in question, consider using a Health Information Service Provider (HISP), such as SureScripts, which can improve communication between the two practices.

6. Use PDSA planning worksheet to test the validity and applicability of each and every change made (see appendix for description of PDSA and the PDSA worksheet).

7. Identify metrics to evaluate the effectiveness of the interventions you develop and deploy (see CRL measures provided in this tool kit). **

8. Build structure into the reporting mechanisms to address the accuracy and timeliness of data and PDSA testing. **

9. Make sure the dyad team meets consistently with routine involvement of referral experts. **

10. Set up the expectation for rapid spread throughout each practice in the dyad. Identify practice partners on each side of the dyad (PCP and Specialist) that will lead testing of the dyad’s newly implemented referral process (choose physicians as the champions who will support process improvement). **

**Intervention Phase Activities (months 5-6)**

1. Test and monitor how each of your tools and systems are working before you implement to make sure the redesign for each step of the process.

8. Survey both primary care and specialist physicians post implementation to determine satisfaction with the referral process (sample satisfaction surveys for the PCPs and for the Specialists are included in the tool kit).

2. After surveying physicians, you may wish to survey patients using the sample survey in the tool kit. Consider adding a question that asks the patients about their understanding of the clinical question and whether they understand its importance and the outcome of the referral visit. **

3. Revise tools and processes as feedback warrants

**Project Surveillance and Management (ongoing)**

1. Analyze data to assess the level of improvement

2. Adjust your interventions as necessary based on your data or feedback from involved team members

3. Routinely share data with dyad partner.

4. Continue to monitor performance and revise activities as necessary
Lessons Learned

The lessons learned in the pilot project include: early face-to-face meetings between PCP/referral team and specialist/referral team is needed to identify office referral experts and change agents, as well as to gain early commitments. The referral experts in each office are the primary force in building efficient and effective referral processes and a good working relationship is critical to improvement. Overall, multiple change strategies are needed that address culture, communication and processes.

Key lessons learned in the CRL pilot revolve around changes in the EHR, the impact of office staff and physicians on referral process improvement, the spread of referral process to additional PCPs and specialists, and the value and placement of the clinical question. Making changes in the EHR that support the referral process proved to be extremely difficult, requiring extensive customization in the EHRs or the use of a HISP. In terms of the office, identifying a referral data management expert (i.e., “Referral Coordinator”) improved referral workflow, consistency, and the number of closed referrals within the timeframe, and having a physician champion was critical to making improvements, even though day-to-day changes were led and managed by staff. In addition, staff training in the referral management process and systems was necessary to ensure sustaining the improvements and gain made by the office. Spreading the referral processes within the dyad offices (PCP and Specialist) improved workflow, consistency, and facilitated the achievement of EHR Meaningful Use Stage 2 standards. A clear and concise clinical question improved the value and relevancy of the referral and standardizing the location of the clinical question/response within the referral request promoted consistency and accuracy. The key lessons can be used in future implementation efforts.
The Care Compact

There are several change package ideas provided in this tool kit and none were more important than the Care Compact during the pilot project. It will be your starting point.

So, what is a Care Compact? They are formal written documents that enhance relationships and communication between primary care and specialist physicians. They are essential elements of advocacy for high quality, safe, effective and coordinated patient-centered care. Care Compacts clarify the role and responsibilities and mutual expectations of providers and make “heroic” efforts unnecessary. It should be noted that effective care coordination requires primary care and specialist physicians’

- Recognition of personal and system interdependence
- Willingness to formalize their mutual expectations
- Collective commitment to timely, bi-directional, meaningful information exchange
- Collaborative engagement in shared decision-making with patients

A sample Care Compact is included in the Appendix.
Key Change Package Ideas

Based on the experience of the pilot project, the following activities were identified as those that are likely to have the greatest impact on improving the patient referral management process. Experience and readiness will vary from practice to practice and these ideas should be used as a guide. Once you have completed the Readiness Survey in this tool kit, you will want to create a project plan based on the example provided in the tool kit. You can use the Plan, Do, Study, Act (PDSA) worksheet to help test any changes you make to your referral management process before implementing.

**Shared Care Compact** – The compact between the PCP and specialist that outlines the expectations for both physicians during the referral process (e.g., to gain agreement regarding referral types and definitions, role expectations, electronic functionality highlighting the clinical question and communications expectations). Patient information that should be included with each referral should be defined. Compacts will define expectations for communication between the dyad as well as with the patient being referred. This compact will specify the process of electronically posing and answering the clinical question. The agreements will evolve and should be reviewed and updated every 6 months.

**Patient Engagement** – A patient referral checklist will be given to patients by the PCP prior to their specialist visit. The document provides information to prepare patients for their upcoming specialist appointment and specifically highlights the clinical question and reason for the specialist visit.

**Clinical Question** – The clinical question the PCP is asking the specialist to answer will be included in each electronic referral, and also noted in the specialty returned noted by the specialist with the answer to the clinical question.

**Referral Definition** – Urgent, emergent and routine referrals definitions including timeframe are defined by the project and documented within the Shared Care Compact.

**Electronic Communication** – The electronic health record system(s) (EHR) used by each dyad member will be used to send and receive all patient information to and from the PCP and specialist including the clinical question. Mechanisms to enhance interoperability such as direct provider to provider messaging and health information exchange methods.

**Process Mapping** – Process mapping will be performed by each dyad member to identify hand off issues and redundancies in the referral process that have led to poor coordination, untimely care and increase patient safety risk.

**Referral Tracking System** – An electronic tracking system that records information about each referral will be implemented at each site and accessible to the participating physicians and clinic staff.

**Referral Reporting System** – Data for project measures would be obtained from the EHR, aggregated and sent to the project office (TWC) for benchmarking and improvement tracking at the individual dyad sites and overall project levels.
Referral Coordinator Responsibilities (Optional) – A role specifically designated in the PCP and specialist office to manage and track all referrals and “no shows.” (see job description, page 30.)

Quality Improvement Training – Quality Improvement training, including process mapping, root-cause analysis, improvement idea generation, PDSA, and sustainment will be provided to the residents and dyad collaborative participants.

Participation in the Collaborative – Participation in the collaborative will focus attention on the factors affecting closing the referral loop, provide a learning environment, as well as instruction and peer support in making improvements.
Essential Aspects of the Referral Change Process

Following the conclusion of the pilot project, PCPI contracted with evaluation experts at The Evaluation Institute, Graduate School of Public Health, University of Pittsburgh, and they were able to identify the essential components of the change process by which referral loops can be closed through review of the project structure and interviews with the participating physicians.

In the current healthcare environment, physicians and practice managers are heavily burdened with reporting requirements. They are often struggling with assimilating information and technology that is new for them. Together, these forces of change are creating huge additional pressures for primary care and specialty practices. If we are to get the buy-in needed to improve the patient referral processes, the intervention must be as simple as possible and, more importantly, fit within the current context of medical care services.

1. **Physician leadership within practice settings.** For change to occur it is essential that physicians commit to addressing referral loop challenges and to communicating with their dyad counterparts. Establishing the Care Compact early in the CRL process may help to demonstrate commitment and create momentum. Physicians also play critical roles in motivating staff and holding staff members accountable, further ensuring that referrals are addressed as clinically appropriate.

2. **Technology.** Electronic health records systems must be finessed so that information is sufficiently and efficiently shared between PCPs and specialists. Depending on the EHR package that is used, this can be accomplished by activating HISPs or, if necessary, by creating alternative processes for peer-to-peer sharing.

3. **Identify staff responsibility for follow through and data collection.** The PCP and specialist must have a staff member on site with responsibility to create workflow change, track data, and champion continued efforts. The actual staff position is likely not as important as having someone in this role with the motivation, designated authority, and commitment to improving quality via outcomes-based care.

4. **Data and Quality Monitoring.** The collection of data for quality monitoring purposes is a key component of the change process. It is only by reminding practices when they are on or off course that any assurance can be obtained that the Closing the Referral Loop process once started will be maintained over time.

   In an interview, one participant shared that improvement was not that difficult: “**Once we decided to do it, Dr. Smith and I just rolled up our sleeves and made it happen.**”

   Another physician noted, “**The most valuable part of the project was trying to standardize lines of communication. This should be the #1 thing to focus on.**”
Patient Engagement in the Referral Process

Improving referral processes within the primary care and specialist physician relationship is only part of the solution to the referral loop issue. Even if each dyad could process referrals as planned every time, patient “no shows” still create the possibility for gaps in referrals. Although the pilot project originally planned to explore patient engagement in depth, the infrastructure changes of the referral management process took priority. Based on the experience of participating physicians and the recommendations of the project evaluators, we offer the following points to improve patient engagement.

- Communication with patients
  - Manage patient language barriers at the specialty office appointment
  - Referral Coordinator manages referrals and makes appointments for patients
  - Specialist scheduling coordinator makes patient aware of appointment and importance of keeping specialist appointment
  - Specialist office calls patient directly to schedule appointment
  - Scheduler calls patient and sets up appointment instead of waiting for patient to call
  - Explore opportunities for health literacy via patient stakeholder representation
- Communication with dyad counterpart
  - Scheduler sends appointment time to primary care physician (PCP office confirms appointment with patient)
  - Scheduler schedules patient appointment and lists it on referral form and faxes to PCP
- Management of “No Shows”
  - Residents contact patients who do not appear for their specialist appointment to find out why they missed their appointment
  - Patient “No shows” reported to specialist
- Closing the Loop
  - After the PCP office gets a referral note, his/her office will call the patient and schedule a return follow-up appointment

We also suggest increasing health literacy opportunities for patients so that they not only understand the importance of following through with specialty referrals but also feel empowered to do so.

There are several excellent health literacy resources available, including:


Quick Guide to Health Literacy: Fact Sheet

Health Information Technology Improvements

Many of the workflow changes implemented in the pilot project were designed as workarounds for incompatible EHRs. Because of pilot dyads’ experience, PCPI has entered conversations with a group of leading EHR vendors facilitated through the U.S. Office of the National Coordinator for Health Information Technology (ONC) to develop a minimum standard for messaging, consistent locations for the clinical question, laboratory tests, imaging results, and an indicator for whether the referral was closed.

To be specific, the clinical question needs to be a separate trackable field within the referral with high visibility for the specialist. Current EHR functionality does not allow easy preparation of the referral. Generally, the PCP must “free text” the clinical question and occasionally the type of referral which is not currently a new meaningful use standard. Lack of electronic linkages between EHRs makes identification of the clinical question and automated routing of specialist/PCP documentation difficult.

We anticipate that the minimum standard will enhance interoperability and facilitate closing the referral loop based on the experience with nine different EHRs being used among the participants in the pilot project and include:

- Automatically update in the PCP referral screen the status of the of the patient’s specialist appointment in the EHR.
- Ability to contact the specialist’s office for updates on outstanding referrals via email or telecommunication.
- Automatically update the PCP EHR of patient “no-shows”
- Eventually, provide information to the specialist about the need for language notification and translation service requests
- Add a field to check availability of specialist, and his/her colleagues within required time
- Add a separate field for the “status of referral” (e.g., Priority or Routine), which allows closure and the ability for PCP to track for follow-up with patient.

While the minimum standard is being developed, and implemented, a Health Information Service Provider (HISP) may be a temporary solution.

“A HISP is an organization that manages security and transport for health information exchange among health care entities or individuals using the Direct standard for transport. There is no specific legal designation for a HISP, nor are HISPs specifically regulated by Meaningful Use certification rules. The term HISP was coined to describe specific message transport functions that need to be performed to support scaled deployment of the Direct standard in the market. HISPs can be performed by existing organizations (such as EHR vendors or hospitals or HIE organizations) or by standalone organizations specializing in HISP services.”

Simply stated, a HISP is an organization that manages surety and transport/exchange of health information. It uses Direct Standards for transport and management and is NOT regulated by federal Meaningful Use certification rules. Direct Trust is a private, non-profit organization that offers voluntary
accreditation of HISPs working closely with the U.S. Office of the National Coordinator (ONC) for Health Information Technology.

For more information, you may want to read this article:

http://geekdoctor.blogspot.com/2014/03/a-primer-on-meaningful-use-and-hisps.html

The HISPs used in the CRL pilot project most often were eClinicalWorks and SureScripts. There are others such as eLINC, Allscripts/MedAllies, AthenaHealth, WellPoint/Alere, DataMotion and CORHIO. It should be noted that HISPs available to you may vary greatly depending on where you are geographically located. Your state health department may be able to offer you a list of HISPs in your area.

For more information about HISPs, please visit:


https://www.healthit.gov/policy-researchers-implementers/direct-project


https://www.healthit.gov/sites/default/files/implementationguidefordirectedgeprotocolsv1_1.pdf


https://www.healthit.gov/sites/default/files/directbasicsforprovidersqa_05092014.pdf


http://wiki.directproject.org/Best+Practices+for+HISPs
Appendix: Quick Review – Using PDSA

Plan, Do, Study, Act (PDSA), is an excellent way to get your improvement work started. Here is a quick review of the method and steps, as well as what you should do during each of the four phases. PDSA provides you a way to answer the following questions before committing to implementing a change.

- What question(s) do we want to answer?
- What are our predictions about the change?
- Does the data indicate the change is an improvement? (Quantitative and qualitative data collected)
- Can the improvement be sustained?
- Are we ready to implement? If not, can we revise and retry or do we need to start over?

**Plan**

- State the objective or purpose
- Make a prediction of what will happen and why
- Develop a plan to test the change (Who? What? When? Where? What data needs to be collected?)

**Do**

- Test the change on a small scale (e.g., one patient, one unit, one shift, one hour – “1:1:1 test”)
- Document what happened – problems and unexpected observations
- Begin data analysis

**Study**

- Complete data analysis
- Compare data to predictions
- Summarize learnings and think about meaning

**Act**

- Adopt, adapt, abandon the change based on results of the test
- Prepare plan for next test or for implementation

**Where to start:**

You may wish to use the “1:1:1” test. For example: 1 patient, shift, 1 day. Once you’re satisfied that the improvement has merit, you can try it with 5 patients, and then 25 to make sure it works in a variety of patients in a variety of situations. Once you are satisfied you want to implement the change, finalize it with a process flow map, appropriate checklist, work orders, a policy statement, education and training, and changes to the EHR.
Appendix: Sample PDSA Planning Worksheet

DATE __________

Aim statement: What do you want to accomplish and by when?

Purpose of this PDSA Cycle:

Is this cycle used to develop, test, or implement a change? ________________

What question(s) do we want to answer with this PDSA cycle:

PLAN:

Plan to answer questions: What, Who, When, Where

<table>
<thead>
<tr>
<th>What are we developing, implementing or testing?</th>
<th>To whom are we testing the change?</th>
<th>When is the test going to be done?</th>
<th>Where will the test occur?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Plan for collection of data: What, Who, When, Where

<table>
<thead>
<tr>
<th>What data do we need to collect?</th>
<th>Who will collect the data?</th>
<th>When will the data be collected?</th>
<th>Where will data be collected?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

Predictions (for questions above):

Do: Report what happened: the completed change or test; data; and begin analysis.

Study: Complete analysis of data.

Compare the data to your predictions and summarize the learning.

<table>
<thead>
<tr>
<th>Prediction</th>
<th>Specificity</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Act: Are we ready to make a change (adopt, adapt, abandon)? Plan for the next cycle:

<table>
<thead>
<tr>
<th>Are we ready to implement?</th>
<th>What changes can we make before the next cycle?</th>
<th>What will be the next test?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>
Appendix: Sample Readiness Assessment for CRL Improvement Activity

Use the following assessment tool to understand the current state of your referral management process as a way to kick off your efforts to improve your ability to close the referral loop.

1. Does your practice use paper or an EHR?
   - Paper □ EHR □

2. Does your clinic use EHR or fax for sending referral?
   - EHR □ Fax □

3. Is the clinical question sent with the referral?
   - Yes □ No □

4. Is the appointment scheduled in a timely manner?
   - Yes □ No □

5. Do you receive a specialist note in a timely manner?
   - Yes □ No □

6. How do you receive the note back?
   - EHR □ Fax □ Other □

   Be specific:

7. Reasons for delays:

8. How do you gather patient feedback?
   - Patient survey □ Patient log □ EHR □ Paper □ Excel spreadsheet □ Other □

9. How do you track referrals?
   - EHR □ Paper □ Excel spreadsheet □ Other □

   Be specific:
Appendix: Definition of Terms

Dyad:
- Two practices (one primary care and one specialty) working together to improve the quality of referral management (processes and outcomes)

Referral:
- A new patient is referred by the PCP to a Specialist to answer a PCP’s clinical question
- A new clinical question is posed by the PCP for a patient currently being co-managed by the CP and the Specialist (this does not include questions asked in the normal course of treatment for previous clinical questions(s) being managed over a 12-month period)

Types of Referrals (time-stratified):
- URGENT referral: referrals that require the patient to be seen by the specialist immediately to within 3 – 7 days.
- PRIORITY referral: referrals that require the patient to be seen by the specialist within 14 days (from referral sent to referral seen)
- ROUTINE referral: referrals that require the patient to be seen by the specialist within 28 days

PCP sends Referral with **Summary of Care Record** (Eligible Professional EHR MU Core Measure 15) to Specialist including:
- Care Plan field (goals and instructions)
- Care team (other providers)
- **Reason for Referral – Clinical Question**
- Current problem list
- Current medication list
- Current allergy list

Specialist sends Referral Report with an answer to the **Clinical Question**.
Appendix: Definitions of Original Measures

- **Total number of referrals**: referrals closed over the previous 3 months, reported on a per month basis.
- **Urgent referrals closed**: urgent referrals closed over the previous 3 months as a percentage of the total number of referrals closed over the previous 3 months, reported on a per month basis at the end of the current or third month. (Measure definition to cover three months of data to allow enough time for referral initiation and closure and thus prevent loss of data).
- **Priority referrals closed**: priority referrals closed over the previous 3 months as a percentage of the total number of referrals closed over the previous 3 months, reported on a per month basis at the end of the current or third month. (Measure definition to cover three months of data to allow enough time for referral initiation and closure and thus prevent loss of data).
- **Routine referrals closed**: routine referrals closed over the previous 3 months as a percentage of the total number of referrals closed over the previous 3 months, reported on a per month basis at the end of the current or third month. (Measure definition to cover three months of data to allow enough time for referral initiation and closure and thus prevent loss of data).
- **Total timely referrals closed**: referrals closed within 7 days of the patient’s completed appointment with the specialist, as a percentage of total open referrals initiated over the previous 3 months, reported on a per month basis at the end of the current or third month.
- **Urgent timely referrals closed**: urgent referrals closed within 7 days of the patient’s completed appointment with the specialist, as a percentage of total urgent open referrals initiated over the previous 3 months, reported on a per month basis at the end of the current or third month.
- **Priority timely referrals closed**: priority referrals closed within 7 days of the patient’s completed appointment with the specialist, as a percentage of total priority open referrals initiated over the previous 3 months, reported on a per month basis at the end of the current or third month.
- **Routine timely referrals closed**: routine referrals closed within 7 days of the patient’s completed appointment with the specialist, as a percentage of total routine open referrals initiated over the previous 3 months, reported on a per month basis at the end of the current or third month.
- **Clinical question answered**: clinical question answered by the specialist physician (as determined by the primary care physician and based on clinical question asked by the primary care physician) as a percentage of the total closed referrals over the previous 3 months, reported on a per month basis at the end of the current or third month.
- **Referral closed date in relation to next PCP appointment**: number of days from the PCP receiving the specialist referral note and the patient’s next PCP appointment (this was a measure from the beginning of the pilot work but we were never able to get data from the PCP related to it).
- **Patient Survey**: the questions assess the patient’s awareness about the reason for referral, perception of the specialist’s knowledge about their medical history, and understanding of their condition and actions required of them after completing the specialist visit. The 6th question asks for additional comments.
• **Primary Care Physician (PCP) Satisfaction Survey:** the questions attempt to measure the PCP’s perception of aspects of the referral process. The answers to the first four questions on the survey were converted to 5-point Likert scales for frequency (always = 5; often = 4; sometimes = 3; rarely = 2; never = 1), satisfaction (very satisfied = 5; satisfied = 4; neither satisfied or dissatisfied = 3; dissatisfied = 2; very dissatisfied = 1), or agreement (strongly agree = 5; agree = 4; neither agree or disagree = 3; disagree = 2; strongly disagree = 1). The survey was completed by each Primary Care Physician pre-intervention (before learning session 1) and at the end of the pilot (post-intervention). The frequency of responses to each item will be tabulated for each timepoint. The 5th question requires a specific response and will be reported per frequency of response. The 6th question asks for additional comments.

• **Specialist Survey:** the questions attempt to measure the Specialist’s perception and satisfaction with components of the referral process. The answers to the first five questions on the survey were converted to 5-point Likert scales for frequency (always = 5; often = 4; sometimes = 3; rarely = 2; never = 1), or satisfaction (very satisfied = 5; satisfied = 4; neither satisfied or dissatisfied = 3; dissatisfied = 2; very dissatisfied = 1), or agreement (strongly agree = 5; agree = 4; neither agree or disagree = 3; disagree = 2; strongly disagree = 1). The survey was completed by each Specialist before learning session (pre-intervention) and at the end of the pilot (post-intervention). The answer to each question will be averaged across all Specialists completing the survey before and after the pilot. The 6th question requires a specific response and will be reported per frequency of response. The 7th question asks for additional comments.
Appendix: Satisfaction Surveys (developed by Expert Panel)

Patient Survey

Q1. Before today’s visit, did you know why you were sent to see a cardiologist?
   - Yes
   - Not sure
   - No

Q2. Did your cardiologist know the purpose of your visit?
   - Yes
   - Not sure
   - No

Q3. How much did your cardiologist know about your medical history?
   - Knew all the important information
   - Knew some of the information
   - Knew a little of the information
   - Did not know my medical history

Q4. After today’s visit, do you feel you...
   - Have a better understanding of your heart condition
   - Did not learn any new information
   - Have a worse understanding of your heart condition

Q5. Do you know the next steps for your plan of care, such as medication or follow-up appointments?
   - Yes
   - Not Sure
   - No

Q6. In the space below, please include any additional comments you have regarding this visit, or the communication between your primary care physician and cardiologist.
Primary Care Physician (PCP) Survey

Q1. How often do you send information to cardiologists regarding the clinical question to address in a referral visit before they see the patient?
   - Always [5]
   - Often [4]
   - Sometimes [3]
   - Rarely [2]
   - Never [1]

Q2. To what extent do you agree or disagree that you know the specific type(s) of information cardiologists want to receive from you before seeing referred patients?
   - Strongly Agree [5]
   - Agree [4]
   - Neither agree nor disagree [3]
   - Disagree [2]
   - Strongly Disagree [1]

Q3. How satisfied are you with your current method of sending referral information to cardiologists?
   - Very satisfied [5]
   - Satisfied [4]
   - Neither satisfied nor dissatisfied [3]
   - Dissatisfied [2]
   - Very dissatisfied [1]

Q4. How often do cardiologists send you a visit summary for the patients you’ve referred?
   - Always [5]
   - Often [4]
   - Sometimes [3]
   - Rarely [2]
   - Never [1]

Q5. How are you currently sending referral information to cardiologists? Please select all that apply. To accommodate the Likert scale, the question was changed to “How satisfied are you with the methods you use to send referral information to the cardiologist?”
   - Fax
   - Over the phone
   - Through EHR
   - Other (please specify)
   - None of the above, not currently sending any referral information

Q6. In the space below, please include any other comments related to the referral process between you and cardiologists.
Specialist Survey

Q1. How often do you receive information from primary care physicians regarding the clinical question to address in a referral visit before you see the patient?
   - Always [5]
   - Often [4]
   - Sometimes [3]
   - Rarely [2]
   - Never [1]

Q2. To what extent do you agree or disagree with the following statement: Primary care physicians know the specific type(s) of information I want to receive before seeing referred patients.
   - Strongly Agree [5]
   - Agree [4]
   - Neither agree nor disagree [3]
   - Disagree [2]
   - Strongly Disagree [1]

Q3. To what extent do you agree or disagree with the following statement: I typically have all the information I need before I see a referred patient.
   - Strongly Agree [5]
   - Agree [4]
   - Neither agree nor disagree [3]
   - Disagree [2]
   - Strongly Disagree [1]

Q4. How do you currently receive referral information from primary care physicians? Please select all that apply. To accommodate the Likert scale, the question was changed to “How satisfied are you with the methods you use to send referral information to the cardiologist?”
   - Fax
   - Over the phone
   - Through EHR
   - Other (please specify)
   - None of the above, not currently sending any information before the visit

Q5. How satisfied are you with your current method of receiving referral information from primary care physicians?
   - Very satisfied [5]
   - Satisfied [4]
   - Neither satisfied nor dissatisfied [3]
   - Dissatisfied [2]
   - Very dissatisfied [1]
Q6. How often do you send primary care physicians a visit summary for the patients they have referred to you?
   - Always [5]
   - Often [4]
   - Sometimes [3]
   - Rarely [2]
   - Never [1]

Q7. In the space below, please include any other comments related to the referral process between you and primary care physicians.
Appendix: Sample Referral Coordinator Job Description

The Wright Center for Graduate Medical Education

Job Posting

Position: Document Specialist

Location: Jermyn Office

Date: June 2017

Job Summary

This position provides timely review and facilitation of provider requests for processing and scheduling of patient orders, testing and referrals to ensure patient safety and quality. This position provides quality customer service to patients via alternate communication methods (telephone, email, etc.).

ESSENTIAL JOB DUTIES

Timely review and facilitate provider requests for processing and scheduling of patient orders, testing and referrals.

Follow-up and resolve outstanding tests, orders and referrals to assure timely and accurate scheduling, processing and availability of results for providers.

Communicate clearly and professionally with patients, staff, and outside facilities.

Be well organized in approach to management of outstanding tasks.

Complete all work functions timely and efficiently.

Be attentive to urgent patient needs and follows up with patients and facilities to assure continuity of timely patient care. Identify and report any unmet urgent patient need.

Follow-up with providers and or practice manager on outstanding documents preventing processing of tests/orders/referrals.

Accurately and timely respond to needs of patients and providers.

Accurately and timely process requests.

Accurately and timely link documents to patient chart for provider information.

Medical Records outgoing

OTHER FUNCTIONS AND RESPONSIBILITIES
• The position works in close support of clinic medical director, physicians, nurses, care manager and other providers.
• HIPAA policies regarding privacy and security of patient health information will be exercised by this position at all times.
• Perform other duties as assigned.

QUALIFICATIONS

• Previous experience in healthcare (1-3 years)
• Demonstrated appropriate knowledge of/for identifying medical documents (labs, tests, x-rays, etc.)
• Experience in a physician office practice setting preferred
• High school graduate or equivalent.
• Strong written and oral communications and interpersonal skills.
• Must have working knowledge of electronic medical records.
• Computer knowledge and skills required.
• Ability to work independently and as a team
• Ability to work flexible hours including evenings, weekends and holidays.
• Ability to work in a fast-paced environment.
• Good judgment and decision-making skills.
• Ability to uphold patient confidentiality with the utmost professionalism.

The Wright Center is an equal opportunity employer. Please send cover letter and resume to Human Resources at hr@yourorganization.org
Appendix: Sample Collaborative Care Compact

The primary care practice of Dr. ________ and the cardiology practice of Dr. ________ have developed a Collaborative Care Agreement. This agreement is based on the following agreed upon collaborative care guidelines.

Collaborative Guidelines

Aim Statement

Our aim is to improve the coordination of patient care between our offices. Specifically, we aim to ensure: 1) patients are seen in an appropriate time frame; 2) clinical questions and responses are clearly stated and effectively communicated from one office to another; and 3) patients understand the reason for their referral and are satisfied with the referral process.

Principles

- Safe, effective and timely patient care is our central goal.
- Effective communication between primary care and specialty is key to providing optimal patient care and to elimination of waste and excess costs related to health care.
- Mutual respect is essential to building and sustaining a professional relationship and working collaboration.
- A high functioning medical system of care provides patients with access to the ‘right care at the right time in the right place at the right cost’.

Definitions

- Primary Care Physician (PCP) – a generalist whose broad medical knowledge provides first contact, comprehensive, and continuous medical care to patients.
- Cardiologist – a physician with advanced, focused knowledge and skills who provides care for patients with complex problems of the heart and vessels.
- Referral - A new patient is referred by the PCP to a Cardiologist to answer a PCP’s clinical question or a new clinical question is posed by the PCP for a patient currently being managed by the PCP and the Cardiologist (this does not include questions in the normal course of treatment for a previous clinical question(s) being managed over a 12-month period of time.)
- Time Stratified Referrals
  - Urgent Referral – referrals that require the patient to be seen immediately (the verbal or written handoff is the referral and once completed the referral is considered to be closed).
  - Priority Referral – referrals that require the patient to be seen by the Cardiologist within 14 days.
  - Priority Patient Preference Referrals – referrals with appointments that are not in the specified time period due to patient preference.
  - Routine Referral – referrals that require the patient to be seen by the Cardiologist within 28 days.
  - Routine Patient Preference Referrals – referrals with appointments that are not in the specified time period due to patient preference.
• **Prepared Patient** – an informed and activated patient who has an adequate understanding of their present health condition in order to participate in medical decision-making and self-management.

• **Cardiology Referral Specialist** – a team member in the office who is responsible for receiving the referral request from the PCP, overseeing the referral process in the office, and sending the referral document with the clinical question to the Cardiologist.

• **Clinical Question** – the question asked by the PCP to the Cardiologist; determined by PCP with the patient after discussion of the diagnosis, prognosis, and treatment options, and expectations taking into consideration the patient’s personal needs.

• **Patient-Centered Medical Home** – a community-based and culturally sensitive model of primary care that ensures every patient has a personal physician who guides a team of health professionals to provide the patient with accessible, coordinated, comprehensive and continuous health care across all stages of life.

• **Medical Neighborhood** – a system of care that integrates the PCMH with the medical community through enhanced, bidirectional communication and collaboration on behalf of the patient.

**Primary Care – Specialty Care Compact**

**Referral**

• Referral - A new patient is referred by a PCP to the Cardiologist. A clinical question is posed by the PCP for a patient currently being co-managed by the PCP and the Cardiologist (this does not include questions asked in the normal course of treatment for previous clinical question(s) being co-managed over a 12-month period of time). PCP sends Summary of Care Record with Referral to Cardiologist that includes:
  o Plan of Care field (goals and instructions)
  o Care team (other providers)
  o Reason for Referral – **Clinical Question**
  o Current problem list
  o Current medication list
  o Current allergy list

• Referral Type - Based on urgency of care required, PCP marks the referral as:
  o Urgent Referral – immediate referral per phone.
  o Priority Referral – Referrals that require the patient to be seen by the Cardiologist within 3-14 days (from referral sent to patient seen)
  o Routine Referral – Referrals that require the patient to be seen by the Cardiologist within 28 days (from referral sent to patient seen).

• Appointment Scheduling – The patient is scheduled for an appointment with the Cardiologist office schedules per type of referral and patient preference.
  o Closing the Loop – Once the patient is seen by the Cardiologist, the Cardiologist sends the visit note to the PCP with the clinical question answered within one week of the appointment.
  o No Shows – If the patient doesn’t show up as per the scheduled appointment, the Cardiologist marks it as one of the following and sends it back to the PCP:
    ▪ No Show – Priority Referral
    ▪ No Show – Routine Referral
  o Delayed referral timing due to:
    ▪ Delayed Priority Referral – Patient Preference
    ▪ Delayed Routine Referral – Patient Preference
Referral Flow:

Primary Care – Specialty Care Compact

Mutual Agreement for Referral Management

- Review tables and determine which services you can provide.
- The Mutual Agreement section of the tables reflects the core element of the PCMH and Medical Neighborhood and outline expectations from both primary care and specialty care providers.
- The Expectations section of the tables provides flexibility to choose what services can be provided depending on the nature of your practice and working arrangement with PCP or Cardiologist.
- The Additional Agreements/Edits section provides an area to add, delete, or modify expectations.
- After appropriate discussion, the representative provider checks each box that applies to the commitment of their practice.
- When patients self-refer to Cardiologist, processes should be in place to determine the patient’s overall needs and reintegrate further care with the PCMH, as appropriate.
- The agreement is waived during emergency care or other circumstances that preclude following these elements necessary to provide timely and necessary medical care to the patient.
- Each provider should agree to open dialogue to discuss and correct real or perceived breaches of this agreement, as well as, on the format and venue of this discussion.
- Optimally, this agreement should be reviewed every year.
Primary Care – Cardiologist Care Compact Examples

### Transition of Care (Referral Management)

#### Mutual Agreement

- Maintain accurate and up-to-date clinical record.
- When available and clinically practical, agree to standardized demographic and clinical information format such as the Continuity of Care Record (CCR) or Continuity of Care Document (CCD).
- Ensure safe and timely transfer of care of a prepared patient.

#### Expectations

<table>
<thead>
<tr>
<th>Primary Care</th>
<th>Cardiologist Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>• PCP maintains complete and up-to-date record including demographics</td>
<td>• Identifies a specific referral contact person to communicate with in the PCP office</td>
</tr>
<tr>
<td>• Transfers information as outlined in Patient Transition Record</td>
<td>• Assist PCP scheduler in adding an appointment time when no appointments with cardiologist are available per the referral timeline or patient preference.</td>
</tr>
<tr>
<td>• Orders appropriate studies that would facilitate the Cardiologist visit.</td>
<td>• Communicates with the patient prior to the appointment regarding appropriate pre-referral work-up</td>
</tr>
<tr>
<td>• Provides patient Cardiologist contact information &amp; expected time frame for appointment</td>
<td>• Informs patient of need, purpose, expectations and goals of transfer</td>
</tr>
<tr>
<td>• PCP referral Cardiologist facilitates the Transition of Care by communicating directly with the Cardiologist office.</td>
<td></td>
</tr>
<tr>
<td>• Patient and/or family are in agreement with the referral, type of referral, and selection of Cardiologist</td>
<td></td>
</tr>
<tr>
<td>• Determines and/or confirms insurance eligibility</td>
<td></td>
</tr>
<tr>
<td>• Works with patient to select and schedule an appointment with the Cardiologist within the cardiology schedule.</td>
<td></td>
</tr>
</tbody>
</table>

### Addendum

#### Additional Agreement/Edits
Primary Care – Cardiologist Care Compact

Access

**Mutual Agreement**

- Be readily available for urgent referrals help to both the physician and patient
- Provide adequate visit availability
- Be prepared to respond to urgencies
- Offer reasonably convenient office facilities and hours of operation
- Provide alternate back-up when unavailable for urgent matters
- When available and clinically practical, provide a secure email option for communication with established patients and/or providers

**Expectations**

<table>
<thead>
<tr>
<th>Primary Care</th>
<th>Cardiology Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Communicate with patients who miss more than 2 appointments with Cardiologist or as needed</td>
<td></td>
</tr>
<tr>
<td>• Determines reasonable time frame for Cardiologist appointment</td>
<td></td>
</tr>
<tr>
<td>• Notifies PCP of missed appointments</td>
<td></td>
</tr>
<tr>
<td>• Reschedules the patient’s missed appointment with the requested provider</td>
<td></td>
</tr>
<tr>
<td>• Provide PCP with a list of practice physicians who agree to agreement principles</td>
<td></td>
</tr>
</tbody>
</table>

Addendum

**Additional Agreement/Edits**

Primary Care – Cardiology Care Compact

**Patient Communication**

**Mutual Agreement**

- Consider patient/family choices in care management, diagnostic testing & treatment plan
- Provide to & obtain consent from patient according to community standards
- Explore patient issues on quality of life in relationship to their specific medical condition and shares this information with the care team
<table>
<thead>
<tr>
<th>Expectations</th>
<th>Cardiology Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Care</strong></td>
<td><strong>Cardiology Care</strong></td>
</tr>
<tr>
<td>• Explains, clarifies, and secures mutual agreement with patient on recommended care plan</td>
<td>• Informs patient of diagnosis, prognosis, and follow-up recommendations</td>
</tr>
<tr>
<td>• Assists patient in identifying their treatment goals</td>
<td>• Provides educational material &amp; resources to patient when appropriate</td>
</tr>
<tr>
<td>• Engages patient in the PCMH concept and identifies whom the patient wishes to be included in their care team</td>
<td>• Recommends appropriate follow-up with PCP</td>
</tr>
<tr>
<td></td>
<td>• Be available to the patient to discuss questions or concerns regarding the consultation of their care management</td>
</tr>
<tr>
<td></td>
<td>• Participates with patient care team</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Addendum</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Additional Agreement/Edits</strong></td>
</tr>
<tr>
<td><strong>Primary Care – Cardiologist Care Compact</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Collaborative Care Management</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mutual Agreement</strong></td>
</tr>
<tr>
<td>• Define responsibilities between PCP, Cardiologist, and patient</td>
</tr>
<tr>
<td>• Clarify who is responsible for specific elements of care (drug therapy, referral management, diagnostic testing, care teams, patient calls, patient education, monitoring, and follow-up)</td>
</tr>
<tr>
<td>• Maintain competency and skills within scope of work &amp; standard of care</td>
</tr>
<tr>
<td>• Give &amp; accept respectful feedback when expectations, guidelines or standards of care are not met</td>
</tr>
<tr>
<td>• Agree on type of care that best fits the patient’s needs</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Expectations</th>
<th>Specialty Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Care</strong></td>
<td><strong>Specialty Care</strong></td>
</tr>
<tr>
<td>• Follows principles of PCMH</td>
<td>• Review information sent by PCP; address provider and patient concerns</td>
</tr>
<tr>
<td>• Manages Cardiologist problem to the extent of the PCP’s scope of practice, abilities &amp; skills</td>
<td>• Confer with PCP &amp; establish protocol before ordering additional services outside of practice guidelines</td>
</tr>
<tr>
<td>• Follows standard practice guidelines related to evidence-based guidelines</td>
<td></td>
</tr>
<tr>
<td>• Resumes care of the patient as outlined by Cardiologist and incorporates care plan recommendations into overall care of the patient</td>
<td>• Confers with PCP before referring to other Specialists; uses preferred provider list</td>
</tr>
<tr>
<td>• Shares data with Cardiologist in a timely manner including data from other providers</td>
<td>• Sends timely reports to PCP; shares data with care team</td>
</tr>
<tr>
<td>• Confers with PCP before referring to other Specialists; uses preferred provider list</td>
<td>• Notifies PCP of major interventions, emergency care, &amp; hospitalizations</td>
</tr>
</tbody>
</table>

Addendum

**Additional Agreement/Edits**
Appendix: Information Needed in Closing the Referral Loop

Primary care physician needs to obtain information from EHR vendor:

- Create an electronic referral request
- Ability to identify Type of Referral
  - Priority vs. Routine
- Ability to attach the “Clinical Question”
- Trackable field for Date of Appointment (DOA)
- Trackable field to attach the specialist’s note

Primary care physician needs the ability to extract the following reports:

- List of open referrals by specialist
- Time for referral created to sent
- Time from referral sent to appointment date
  - Priority vs. Routine
- Referral closed date in relation to next PCP appointment

Specialist physician needs the following information from the EHR:

- Category of referral importance: Priority vs. Routine
- Identify the “Clinical Question” asked
- Electronically communicate date of appointment or date of contact
- Electronically sent the specialist’s note with an answer to the “Clinical Question”

Specialist physician needs the ability to extract the following reports:

- Time from referral received to appointment date
- Time from appointment to note sent

Key components of the outgoing referral document

- Identifies dyad physicians (PCP and Specialist)
- Links clinical question document
- Creates/sends date
- Appointment date and time (made by Specialist’s office) need to be updated and entered at a later date into the same referral document
## Appendix: Example of an Outgoing Referral EHR Screen

![Example Outgoing Referral EHR Screen](image)

**User** | COMMUNITY, COMPUTER  
---|---
**Ref Dr** | 452  
**Ref To Dr** | 1148  
**PCP Dr** | 452  
**Ref Dr** | Sheeth, Aignesh, MD  
**Ref To Dr** | Pancholy, Samir Bipin  
**PCP Dr** | Sheeth, Aignesh, MD  
**Rating** | Normal  
**Home** | (570)-  
**Created** | 05/19/14  
**Sched** | 06/11/14  
**Sent** | 05/20/14  
**RxDPT** | 00/00/00  
**Location** | THE WRIGHT CENTER, MD  
**Dr Note** |  
**Referral Type** |  
**Ins** |  
**Referral #** |  
**Visits** | UNLIMITED  
**Effective** | 05/19/2014  
**Result Letter** | 05/19/2014  
**Alert Report** |  
**Appt Date** | 06/26/2014  
**Time** | 8:00 am  
**Appt Status** |  

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Appendix: Clinical Question Document Example

The Wright Center Medical Group, P.C.
5 S Washington Avenue
Jermyn, PA 18433-1121
Phone: (570)-383-9934

Dear Dr. Pancholy,

After your visit with Aimmie test, I would appreciate your input on the following questions I had:
1. What types of anti coagulation would you deem appropriate for this patient's AFib?

Thank you,

SHETH, JIGNESH M.D.

**PCP USE ONLY**

Was your clinical question answered?  ✔ Yes  ☐ No

**PCP OFFICE USE ONLY**

Was the patient survey completed?  ✔ Yes  ☐ No
Appendix: eFax/Direct Messaging Based Correspondence Example

Sample

Set up at Regional June 23, 2014 at 8:00.
Appendix: What Infrastructure Do You Need to Make Improvement?

- Physician champion
- Project lead with knowledge of your current referral management process and willingness to map your referral process
- Technology-orientation or staff with technology orientation who may assist with changes to your EHR, as well as ways to connect with your physician partners, whether primary care or specialist
- Referral coordinator (or existing staff to take on these responsibilities)
- EHR
- System that facilitates bi-directional communication between primary care and specialist physician offices, which could be an eFax or direct messaging systems such as a Health Information Service Provider (HISP)
- Data collection system to track status of referrals and when they are closed
Resources Used in Creating the Tool Kit

Presentation, PCPI Conference, March 6, 2015, Arlington, Virginia: “Closing the Referral Loop” to Coordinate Patient Centered Care,” Linda Thomas-Hemak, MD, President and CEO, The Wright Centers for Graduate Medical Education and Medical Group; Jignesh Sheth, MD, VP for Mission Accountability, The Wright Centers for Graduate Medical Education and Medical Group; Samir Pancholy, MD, Cardiology Fellowship Program Director, The Wright Center for Graduate Medical Education, North Penn Cardiovascular Specialists.

Closing the Referral Loop: Evaluation of the 2014 Pilot Project. The Evaluation Institute, Graduate School of Public Health, University of Pittsburgh. September 2015. Mary Hawk, DrPH, LSW, Principal Investigator, Edmund M. Ricci, PhD, MLitt, Co-Principal Investigator, Unpublished.

